Adult History Form *(Please print clearly and fill in completely.).*

Date:__________________________ E-mail:____

Patient's Name:____ Birth Date:____________________________

Address: ______________________________________ City: ______________ State: _______ Zip Code: _________

Sex: ☐ Female ☐ Male Status: ☐ Single ☐ Married ☐ Widowed S.S.#:______________________________

Phone: home (_____)__________________ cell (_____)__________________ work (_____)_________________

Patient's Employer: ____ Occupation: ___________________________

Spouse's name (parent's name if minor):______________________________ Phone number: (_____)_______________

Children's names & ages:____

Have you ever been to a chiropractor before? ☐ Yes ☐ No If yes, last appointment date ______________________

Whom may we thank for referring you? ____

Insurance Information:

Name of Insured: _______________________________________ Relationship to Patient:__________________

Insured's S.S.#: ____ Insured's Date of Birth: ______________________

Name of employer: ______________________________________ Work Phone: (______)_______________________

Name of Insurance Company: ______________________________ Phone: (______)_______________________

Insurance I.D. #:_______________________________________ Insurance Group #: _________________________

Accident Information:

Is your condition due to an accident? ☐ Yes ☐ No If yes, date of injury: ___________________________

Type of injury: ☐ Work ☐ Auto ☐ Home ☐ Other____

Insurance Carrier's Name & Address: ____

Adjuster's Name & Phone Number: ____

Certification and Assignment:

To the best of my knowledge, I certify that the information I have provided is complete and correct. I authorize payment of insurance benefits directly to the doctor or this office for services rendered to me. I understand that I am financially responsible for all charges, regardless of insurance coverage or reimbursement. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

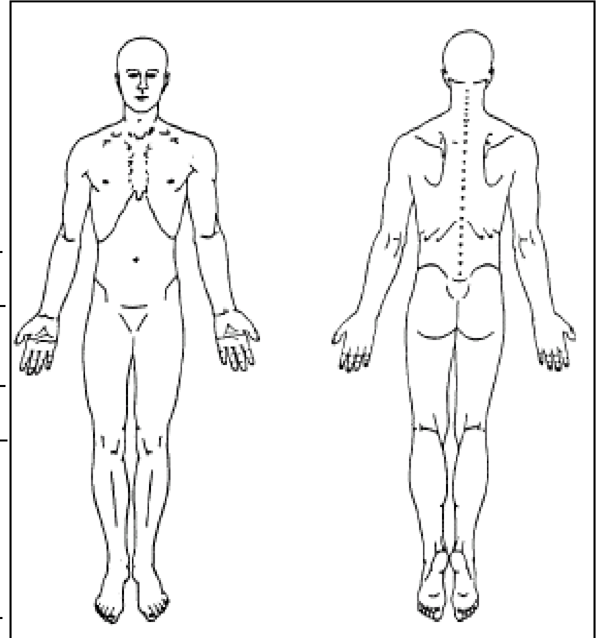
____ ________________________________

Responsible Party Signature ***Date***

Reason for visit:____

Please mark on diagram where you are experiencing symptoms and describe

P=Pain N=Numbness S=Spasm T=Tingling



Which activities are difficult to perform?

☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying down ☐ Other ________________

Other doctors seen for this condition:____________________________

Treatment recommended:____________________________________

Rate severity of your pain. (1 = mild; 10 = severe) ________________

List any current medications: ______________________________

____

List any supplements:______________________________________

Previous surgeries & dates: ________________________________

Previous accidents & dates: ________________________________

Health History *Please check any of the following conditions which are applicable*:

☐ Asthma	☐ Back Stiffness/Pain	☐ Buzzing/Ringing in Ears
☐ Cold Sweats	☐ Cold Hands/Feet	☐ Depression
☐ Diabetes	☐ Diarrhea/Constip./Gas	☐ Dizziness/Vertigo
☐ Fatigue	☐ Foot Problems	☐ Headaches/Migraines
☐ Heartburn/Reflux	☐ High Blood Pressure	☐ Hot Flashes
☐ Infertility/Impotence	☐ Irritability/Mood Swings	☐ Jaw/TMJ Problems
☐ Joint Swelling/Arthritis	☐ Loss of Balance	☐ Loss of Taste/Smell
☐ Menstrual Problems	☐ Neck Stiffness/Pain	☐ Nervousness/Anxiety
☐ Pins & Needles	☐ Pre-menstrual Synd. (PMS)	☐ Problems Urinating
☐ Recurring Infection	☐ Shortness of Breath	☐ Sinus Problems/Allergies
☐ Sleeping Problems	☐ Stomach Upset	☐ Autoimmune Disease ____________________
☐ Tension/Stress	☐ Ulcers	☐ Other ______________________________

Women's Health Last menstruation____________________________________

Is there any chance you are pregnant? ☐ Yes ☐ No If yes, Due Date ______________________________

Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Any problems? ____